

Arkansas Department of Health
HIV Elimination Taskforce Meeting Minutes
Thursday, February 20th 2020

Welcome and Introduction

Dr. Michelle R. Smith began the meeting and welcomed all present. Dr. Michelle R. Smith welcomed the guest speaker for the What HIV Elimination Means to Me, Larry Houston.

What HIV Elimination Means to Me

Larry Houston was tested in August of 2012 after his then-boyfriend tested positive—he did not have any extreme reaction to the news of his boyfriend’s HIV status because he did not have any experience with the virus and did not know how to respond. He and his boyfriend shared the same primary care physician, but had very different experiences due to having different infectious disease doctors. Larry said he would not wish his experience after testing on his worst enemy; he felt he was treated like a criminal and had become the scum of the earth. His first infectious disease doctor lacked bedside manner and made no effort to get to know Larry. Larry said he went from excited and ready to learn about his new status to disheartened and confused about the whole situation. Fortunately, he found a nonprofit organization that guided him to understanding and hope. He felt very fortunate to not have experienced any barriers to healthcare and medication. HIV elimination to Larry Houston would mean people not spending thousands of dollars on medication any longer, thousands of lives saved, no one having to experience what he experienced, and each and every person in the room accomplishing a task and a goal.

Taskforce Progress

- ❖ Tiffany Vance reminded everyone that the co-leads have been sent the names and email addresses for everyone on their team, and asked that they reach out to find a team to meet and discuss their individual pillars. If anyone has any questions, they can reach out to Tiffany Vance at Tiffany.Vance@arkansas.gov.
 - Tiffany Vance updated everyone on the letter to physicians and providers throughout the state in regard to HIV resources that they can look at. Jon Allen helped to draft the letter, which included resources, websites, and information for reaching out to him for more details. The letter was sent to 11,225 providers and 36 providers have responded (a large number of which were family care providers).
 - **Questions:**
 - Are those scattered across the state or all centrally located?
 - All across the state.
- ❖ Tiffany Vance brought up another innovative to create a subgroup consisting of pastors and bishops to activate congregations, address stigma, and make sure we are reaching out to our faith-based community and helping them to reach out to their congregations about HIV issues.
 - A Grand Rounds session has been scheduled for April 2 which will focus on Innovative Faith-Based Community and Clinical Partnerships with Dr. Amy Nunn and Dr. Philip A. Chan.
 - In addition, we will have roundtable discussion called Harness the Power of the Pulpit to End the HIV Epidemic in Arkansas on Thursday, April 2 from 10:00a to 11:30a. We will be inviting individuals and different pastors and ministry leaders to participate in the discussion.

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Dr. Nunn was on call during the meeting, and at this time expressed her excitement to working with the taskforce on the topic of meeting with clergy to discuss HIV elimination. She mentioned she and her group have been previously very successful with this approach in different areas of the country, including in Mississippi.

PREVENT Spotlight

- ❖ Jon Allen lead the spotlight discussion on the third pillar, PREVENT. He has a background in HIV treatment, first in California and then in Arkansas and now at the Arkansas Department of Health. He has been very excited about progression toward HIV elimination in the past, but has recognized the need for more progression in different areas that he touched on.
- ❖ Jon Allen discussed the CDC’s prevention toolbox. He discussed the Ready, Set, PrEP program, a way for those without prescription drug insurance to receive PrEP at no cost. From the program he discovered there are several options around the Arkansas Department of Health, but when you change the zip code to somewhere like Magnolia the options are severely limited—only one in the city and otherwise a PrEP desert around that area. He said this means two things: one, the people who are looking for these options will not be able to find them and two, it is possible that there are in fact PrEP providers there who have not been able to include their information on the site.
- ❖ Jon Allen discussed the PEP Campaign—Post-Exposure Prophylaxis. This is a treatment for people who have been immediately exposed to HIV to help prevent the virus from infecting the person. He discussed an issue where many people experience barriers to access of this medication—the pharmacy could be closed because it is late at night, the pharmacy may not carry the medication, and the pharmacy may present further gatekeeping to prevent access to the medication. He discussed the need for programs for PEP similar to the ones that exist for PrEP to allow patient access in emergency situations, especially the one mentioned before that allows patients to search for providers near them. There was discussion about the need for education for emergency room doctors about PEP and HIV in general to ensure quality care for every patient that comes in, as many scenarios play out where patients do not receive adequate care because their physicians are uninformed about HIV and PEP.
- ❖ Dr. Nunn mentioned she followed about 1,500 patients on PrEP in Jackson, Mississippi, Providence, Rhode Island, and St. Louis, Missouri and found that at the six month end point about 65% of those patients still in PrEP care and about 50% at the one-year end point. The overwhelming majority of those who dropped out of care were for a variety of reasons that could be mitigated by a navigator. She also mentioned her program retains significantly more white patients than black patients, for reasons they do not understand.
- ❖ Jon Allen introduces Dr. Nick Zaller a professor of Health Behavior and Health Education and co-director of the Rural and Global Health Program at the UAMS COPH. Dr. Zaller focuses primarily on criminal justice populations. In Arkansas we have a tremendous number of incarcerated people, and the biggest drivers of that are behavioral health, mental health, and drug abuse issues—nearly 80,000 people are in some sort of criminal supervision in a state of 3 million. We are at the epicenter of incarceration issues in Arkansas, and many people who are incarcerated are high risk and are not being tested. Dr. Zaller and his group at UAMS are bridging the gap for incarcerated people by providing free STD screenings and testing as well as access to PrEP for those who have been released.

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- ❖ Dr. Zaller discussed the issue of protection for injection drug users and the need for programs to allow for the safe and sanitary disposal of used needles to prevent the spread of HIV through those needles. Dr. Smith discussed at length the necessity of widening the range of people who are involved in the conversation about these programs—Dr. Smith touched on the fact that the subject of a used needle disposal program involves many departments other than just public health, namely the law enforcement officers who would be affected by such a program. In all, Dr. Smith stated that it would be problematic to spring such a conversation upon those who would be directly affected by the implementation of such a program, and therefore we should be making an effort to include more of these people in that conversation.
 - **Questions:**
 - “Are there other states/locations that are addressing this issue better than we are here?”
 - “Yes. This is a similar challenge in a lot of other settings. It really depends on the resources of the county and the medical staff.”
 - “Do you do any jails other than Pulaski County?”
 - “At the moment, no. I’ve had some conversations with a few other counties: Garland County, Sebastian, and Hot Springs. I’m hoping that we can do more, I think we can do more in county jails but it’s a question of resources.”
 - “What is the stance on the Pharmacy Association in regard to that? Positive or negative?”
 - “There have been meetings at UAMS with the School of Pharmacy where they have looked into those questions, and pharmacists can have collaborate agreement with a physician that if the physician were to prescribe PrEP initially that pharmacist could follow that patient thereafter without another physician visit and refill the PrEP if certain lab tests continue to be negative. So the School of Pharmacy has signed off on that, the Board of Pharmacy we’ve also consulted with them and they are on board with that.”

PREVENT Discussion

- ❖ Which prevention strategies should be implemented in Arkansas?
 - “Is there another state using transportation services for clients specifically for HIV clients getting to their appointments/pharmacies?”
 - “Medicaid provides transportation services—it’s easier for those who are positive and much more difficult for those who are still negative. There have been discussions about ridesharing and using federal funding to provide transportation to appointments, but as of now it is an issue.”
 - “How many PrEP providers are there in Arkansas and are the majority in central Arkansas? I have heard doctors are reluctant to prescribe in Arkansas.”
 - “From the map shown there are about 8 PrEP providers in Little Rock and there are about 40 scattered about different counties in Arkansas, as far as our database goes. There are some areas in south Arkansas where there is only one in a 50 mile radius. There are problems with doctors being reluctant to prescribe, but many are stepping forward.”

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- “Can you talk more about the telePrEP program in Arkansas and how far along they are?”
 - “Arkansas is one of the most wired states in the nation for telemedicine. Many hospitals and clinics have telemedicine access and education as well. What Jon Allen was referring to was a program where patients could access a secure, HIPAA compliant program through their smartphone to access appointments and medications. A robust telePrEP program would incorporate this type of access.”
- “Why did the system stop testing inmates when they come out?”
 - “Somebody decided that there are people are spreading HIV, but testing found only one confirmed person come out positive so the government decided to stop.”
 - Dr. Smith pushed for this change because it was neither effective nor cost-effective.
- ❖ What programs or ideas would you like to share regarding HIV prevention?
 - Walgreen’s in March is setting up training for employees for Ready, Set, PrEP so any patient can come in and receive that care.
 - The CDC has put out a new funding announcement for ending the HIV epidemic, 25% has to be utilized in regard to community-based organizations and other agencies as far as working with expanding efforts for ending the HIV epidemic activities.

Emergent Issues & Upcoming Events

- ❖ Has anyone encountered a barrier to care since our last meeting?
- ❖ Upcoming Event: HIV and the Faith-Based Community April 2nd, Dr. Nunn and Dr. Chan. Immediately following in the boardroom will be the roundtable discussion “Ending the HIV Epidemic: A Plan for Arkansas” from 10:00a-11:30a.

Next Meeting

April 23rd, 2020 Freeway Medical Center, 2-3:30p. Topic will be 4th pillar, respond.

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Meeting Minutes

Welcome and Introduction

Welcome was extended by Dr. Michelle Smith (Office of Health Equity). Dr. Smith reviewed how the taskforce started hearing from an HIV survivor in August to hear their story, and introduced Cornelius who has been a participant in the meetings since the beginning. Cornelius opened the taskforce meeting with his story.

Presentations

- ❖ Cornelius Maven has been a part of the HIV epidemic since the beginning. He was diagnosed with HIV about 25 years ago. He had to really think back to remember when he was diagnosed because even though some people use their diagnosis date as a sort of birthday, he chooses not to dwell on it. He was diagnosed by his primary care physician (PCP) who was also his pastor when he went to see him for a checkup. His experience was surreal because no one really explained anything to him. When he left the office he decided he would go out and figure out what that diagnosis meant in general and what it meant specifically for him—this included moving on to a different PCP and found one that gave him the guidance he needed. He always worked where he had insurance so he always used his own healthcare access and not the public options that were available. He has never been hospitalized, but he did have to have a bilateral hip replacement—when he discussed his diagnosis with his surgeon, there was the issue of using blood products. As a result, Cornelius harvested his own blood over time to use in the surgery. Because of his age he is now taking a single pill regimen rather than the three pills he used to, and he remarks that he never really had any side effects like many others do. At some point Cornelius realized that even though he was doing very well with his diagnosis, other people were not and that is when he decided to get into activism. Cornelius designed a “living room wellness center” as a space to be a collaborative hub for HIV, Hepatitis C, and PrEP navigational services in one space.
 - Elimination and What it Means to Him
 - The work that he is doing through the living room wellness center and being part of the epidemic, being a one stop place for care and being a place that follows through with clients. Having a place that is people-centered.
- ❖ Chychy Smith discussed the subcommittees that people are encouraged to join. Included in the agenda was a QR code that when scanned would take the participant to a site to sign up to participate in a subcommittee. If you do not want to be part of one of the four groups, you can sign up to be in a supportive role.
- ❖ Dr. Michelle Smith discussed the innovative idea tracker, where ideas from taskforce meetings will be taken from detailed notes on the meetings and placed into a tracker that collects and maintains innovative ideas that others have shared. These ideas will be detailed in the strategic plan.
- ❖ Craig Wilson, a teacher at the College of Public Health, discussed his policy paper (can be found at achi.net).

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❖ Jon Allen filled in for Dr. Bedell. John is an employee in the Infectious Diseases department of the ADH. John gave a presentation overview of what happens when someone comes into the HIV system. When someone tests positive for HIV and comes into the system, people from surveillance make sure that they are linked to care and the STD DIS people link them to the Ryan White program. Then there is an assessment of their needs, in terms of housing, dental, mental health services, etc. If they are uninsured or underinsured the program can help provide them with HIV medications.

- Pros and Cons of Rapid Antiretroviral Therapy
 - Pros: meets the first pillar of treating HIV rapidly and lowering the viral load rapidly, relieves the symptoms and prevents the virus from doing further damage to the system, essential to things like pregnancy for preventing damage to the fetus, and serves as a message to the patient that care begins right away.
 - Cons: you have less time to know the person, some clinics have found it is difficult to sustain when you are completing a therapy that could take 2 or 3 visits in just one.

If you begin therapy early in pregnancy (in the first trimester) there is less than a half percent of passing HIV on to the baby, if you start late in the pregnancy it could be as high as 2%.

- Question for Everyone in the Room: What is our current state of rapid ART in Arkansas?
 - Dr. Moore: We have not really taken up rapid ART in Arkansas due to various barriers—the biggest is that all patients will need assistance to pay for labs and therefore need to go through hoops to find that financial support. We need to have preliminary approval to shorten the time between diagnosis and care. The current intake is 13 pages long.

❖ Dr. Reznick, director of the Oral Health Center's Infectious Disease Program, discussed an initiative to get people in therapy faster. This was done for all patients, whether new or current needing to return to care. January 1 through May 15 was the pre-rapid entry with 117 patients, May 15 through July 31s was post-rapid entry with 90 patients. Before they began they wanted to reduce limitations to getting into the program, wanted to remove administrative requirements, remove the requirement for a completed tuberculosis test, and enhance education in regard to regimen selection without lab results. In their results the median age was 35, age range was 25-45, 80% were male, 91% were African American, 50% were men who have sex with men, 57% were uninsured, and 44% had active substance abuse. The time to viral suppression decreased from 77 days to 57 days. The time from first provider care visit decreased from 17 days to 5 days. Time to antiretroviral initiation decreased from 21 days to 7 days. There were some institutional level, like the certification process—if a patient did not return for recertification after the 30 day grace period, Ryan White would not pay for the bill and therefore the program took quite a hit. It also took some retraining of staff to be able to operate under the new system comfortably.

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○ **Questions/Comments:**

- Is there a reason why there appears to be a retention drop-off after two years?
 - Multiple reasons. One, when things first start going better and you start feeling better people and life begins to get in the way, especially for young people, it becomes difficult to continue treatment. Social determinants of health and institutional barriers can be a serious problem as well. Resources can also become a problem, especially when they quickly run out due to number of participants.
- Dr. Nate Smith: Do you have a way of tracking your patients as they move to other jurisdictions?
 - Some patients are forthcoming about their move and ask for help with figuring out treatment in a new place. What is done for people who move out of care is utilize something similar to an alarm system where if a patient shows up to another place for care, someone on staff will be given a notification so they are able to put them back into care so long as that location is within the same state.

❖ Questions with Dr. Moore and Jon Allen.

- What resources are needed for more widespread implementation of ART in Arkansas?
 - Money. Case managers are staffed throughout the state, but they also have their own patient load to take care of as well. There is a need for new case managers who are focused on this specifically, and maybe also PrEP.
- Would some sort of 30-day grace period policy help?
 - I think that's reasonable. Clients who come in are usually seen by the case manager within a week or so and it is attempted to help them see a doctor within the next clinic visit. If there is a grace period to provide the medication and labs, fill out the 13 page form, this would be great if we could figure out a way to speed up the process.
- How can we do things differently to get people on therapy quicker and get all the benefits of doing so?
 - We need more prescribers. Obtaining the prescription for the medication to be started can be a lengthy process, especially when communication with doctors is complicated. Dr. Moore is finding it necessary to prescribe without seeing a patient because it may take too long to get an appointment and the patient has run out of medicine.
- At the jails is there not a protocol when they are being released that their medications need to be filled before they are let out?
 - When you are being released from ADC or ACC they are given what medications they have when they are released. They would like to have more sheriffs and jail

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workers come to the taskforce meetings. A problem is patients not continuing care after being discharged and then not having medication once what they received from the jail runs out.

- A commenter brought up that they spent time in the Arkansas jail system with high blood pressure and when they left jail they were not allowed to take medications with them. This person now works for UAMS working on HIV prevention and care, and has seen patients who have complained of the same issue, including being retested for HIV despite knowing already that they have been exposed.
- We are working with Anne in the Department of Corrections to get a list of names when patients are 30 days out of jail. Perhaps we can also add a protocol or something to ensure they are linked with a doctor or something once they are discharged. Do you think that is possible?
 - When they are getting ready to be released they are given a list of providers so they can contact them. They are also informed to go and contact their local county health unit to let them know they are there.
 - With the new funding that's coming in we are ensuring that we use HIV-only DIS or community health workers so there will be that other link there to make sure people are getting their medications and care.
 - Parole officers have been known to contact the health professionals necessary to check for patients, and the DOC employees will contact parole officers directly to ensure they are receiving care.
- Any other thoughts about how we can get people into therapy quicker [in the DOC system]?
 - Training of people that are in facilities to know the importance of one day missed or two days missed or a week missed. Doing this to ensure that DOC employees know how critical it is that inmates are receiving every single dose of medication that they need.
 - In the county jails there is not a consistent way that HIV patients are treated among staff. Someone would need to come in and educate the employees of these facilities so they have the information necessary to help these inmates in the best way possible. If everyone was told at a meeting how to access HIV medications quickly we could cut down wait times.
 - Education is the key to getting the information out for everyone.

Next Meeting Date and Time

HIV Elimination Taskforce - Thursday, February 20th 2:00p-3:30p (UTC-06:00) Central Time (US & Canada) Location: Freeway Medical Building Boardroom #906, West 10th Street, Little Rock, AR 72204
Agenda Topic: Prevent
What HIV Elimination Means to Me Speaker: Larry Houston

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4th HIV Elimination Taskforce Meeting Minutes
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Meeting Minutes

Welcome and Introduction

Welcome was extended by Dr. Nate Smith (Arkansas Secretary of Health) and Dr. Michelle Smith (Office of Health Equity & HIV Elimination Director). Today's focus will be Rapid Start Treatment's role in eliminating HIV.

Presentations

- ❖ Danny Harris (ARcare Outreach Coordinator) gave his personal story as someone living with HIV. Danny showed an interesting illustration using The String Theory. With each negative blow he mentioned, he broke off a piece of string. In 2006, Danny was married with 4 children and was in his preferred career of ministry. On January 3, 2006, he went for a life insurance workup at his physician's office. On January 7, 2006, he was attacked and molested. By May he began to show symptoms of HIV (fatigue, weight loss, rashes, night sweats). He didn't want to make an appointment with the doctor. He finally made the appointment (not for testing) but for a wellness check. The doctor called and said he was HIV positive. A bit more of his life broke away. The nurse told him people are living longer than 6-8 months. He was pawned off on another doctor. He received instructions for labs – no guidance, no direction of where to go from there.

Danny met with a DIS (Disease Intervention Specialist) at the Washington County Health Unit. He remembers being told he would now be included in a national database. He felt like anyone could check up on him and like a scarlet A was on his forehead. He lost his marriage, his family and his career. He could not see how he could be a part of everything in his life as before. On his third HIV visit, he received his prescription for his HIV medication. That is when it all became real. He moved to Northwest Arkansas to die alone. Hanging on to inches of string, he was referred to an HIV support group. He met people who had lived with HIV since the 80's and received a glimpse of hope.

He took his meds and life became stronger, but it was not strong (while holding 2 pieces of string together). Three years later he realized what was missing in his life when a case management position opened up at ARcare. He found his missing purpose and significance. Holding all of the broken string together, Danny concluded by saying "A 3 fold cord is not easily broken".

- Barriers he has faced
 - Treatment and care for HIV was not local.
 - The staff he dealt with didn't understand and /or care about linking him to care.
 - He felt pushed into the Ryan White Routine of care.
 - There was a constant barrage of negative words (risky, infected, etc.)
- What would he change regarding HIV?
 - He would make it to where each Ryan White Provider would have a Peer Counselor available.

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- We need more compassionate staff and we need to deal with stigma and apathy.
- Elimination and What It Means to Him
 - “I’m someone who used to have HIV.”
- Questions/Comments
 - What do the three strands stand for?
 - Hope, Medical Care, Purpose and Significance.
 - How do we get to the point of provided much needed services?
 - Figure out a way to provide online services
 - Get more people involved
 - Danny starts support groups (empowerment groups) and tries to find people to stay with them and pay it forward
 - What would you liked to have happen on your first visit?
 - Someone should have provided information (a handout, something to read). He did not have any sort of background in HIV before his diagnosis.
 - Having someone with HIV available to show you can live with it and have hope.
- ❖ Emergent Issues – Has anyone encountered any barriers to care since the last meeting?
 - Fred Love (AR State Representative and Pulaski Co Director of Community Services) shared a situation that arose through the Pulaski Co HOPWA Program (Housing Opportunities for Persons with AIDS). It involved a client with came into care with an infected teenage child who has been sexually active with other students at school. His office contacted ARcare but did not know what became of the situation. Rep. Love asked if there is a protocol for providers for cases like this and if providers know what to do and who to contact.
 - Dr. Naveen Patil (ADH ID Medical Director) answered by stating there is not a written protocol. There is not a one size fits all plan. By the next meeting we will have a list of who to contact.
 - In this situation, this case was handled by ARcare and ADH appropriately resulting in both the parent and child have been linked to care. Arcare is well trained to handles situations like these.
 - The key issue is for providers to know to communicate with ADH.
 - Ann Teer (AR Dept of Correction HIV Coordinator) stated that they have come across sex offenders that are HIV positive and the victims are not saying anything (about what happened to them). Are victims being tested? Is HIV testing being followed though (with their known victims) after the sex offenders’ trials?
 - If a DIS is contacted, they follow up with that case. If the court is not disclosing victims that are children, it will be up to them to be tested. If there is a subpoena, the DIS will let the victims know they need to be tested.
- ❖ Pillar Two Spotlight – Treat
 - Dr. Charles Bedell (ADH Associate Branch Chief) presented the barrier gaps and innovative ideas determined by the sub-committee for Pillar Two – Treat.
 - Treat - Barrier Gaps

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- Lack of rapid treatment for those initially diagnosed or out of care – There is a significant gap between when someone (on the Ryan White Part B Program) is put on Ryan White/ADAP and when they are seen by a physician.
 - Delay in laboratory results
 - Patients missing their appointments
 - Transportation to doctor appointments – How do we get them to the doctor immediately after their diagnosis?
 - Not enough physicians willing to treat HIV – PCPs are not treating HIV because it used to be much more complicated to treat. They turn patients over to ID Specialists
 - ARcare and other physicians are not allowed to give out HIV med samples.
 - Starter packs can be a problem when patients wait until they are down to their last pill to make an appointment for a prescription or to try to get on Ryan White to pay for their care.
 - Treat – Innovative Ideas
 - An HIV Patient Hotline – This was brought up before by Dr. Smith, Dr. Patil and Dr. Moore. This is a good idea as long as the person can receive immediate care.
 - HIV should be seen as any other Infectious Disease
 - Newly diagnosed patients receive medications or a prescription on the same day of their appointment
 - Appointments are scheduled same day
 - Ask during the screening process if they have a PCP and if that doctor is willing to treat them for HIV
 - Start an HIV Physician Hotline to assist doctors and nurses, not patients. ARcare has one but the ones calling in are not from the State of Arkansas.
 - Have the new Ryan White Provider Relations Specialist contact PCPs and find out who will treat HIV
 - Expand Telemedicine
 - Ideas Missed
 - Testing
 - Provider Support and Training
 - The lack of insurance coverage
- ❖ Dr Mark Williams (UAMS Dean of Fay W. Boozman College of Public Health) was asked for his opinion for what would work in Arkansas.
- Realize we are talking to the wrong people. We are not visiting with the ones that need testing and treatment. We need to talk to those who could be affected and find out how to reach them. Use them and their ideas.
 - Some have access to certain populations. Find out how we can get access to those people, for example, mothers on WIC. We could ask if they were diagnosed how would they handle it.

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- Use a mixed approach using focus groups vs. advisory groups.
 - One example of an idea involves one risk factor for HIV is another STD. A new testing kit has come out that is inexpensive. Bring that kit into the jail and test for five STDs including HIV. Would a person in jail consider being tested? What would they do if they receive a positive diagnosis?
 - We have episodes of opioid overdoses. Can we interview these patients in the ER once they are stable?
- ❖ Dr. Jason Halperin (Infectious Disease Specialist, CrescentCare, New Orleans, LA) participated in a video conference with the group. Dr. Halperin shared his passion for the Rapid Start program they use in the New Orleans area in the largest HIV provider in the area.
- Their program replicated the success of the University of California, San Francisco's Ward 86 Rapid Start program—the first in the United States. The model includes treating on the first day of testing positive.
 - They conduct testing in bars and at clubs and festivals.
 - In 2015, the rates of HIV infection was not decreasing and actually the incidents among young gay black males was increasing. That was when they instituted Rapid Start.
 - Before Rapid Start, the timeline for their program was a patient saw a health educator within 7 days of diagnosis, they then saw a nurse and had their labs drawn within the next 7 days and then saw a physician 7 days after that resulting in a 21 day turnaround.
 - They do not need a genotype test to suppress people.
 - In order to make the plan successful, they would need to get all 18 of their providers on board which took about 6 months.
 - All patients at the initiation of care didn't know they already had kidney disease.
 - Over two years they have had zero transmissions.
 - They created a new workflow in order to make the process of treatment much faster. This included flipping the process to where the provider was seen up front. This was in conjunction with the expansion of Medicaid in Louisiana.
 - It takes three weeks for someone to be enrolled in ADAP. With Rapid Start, ADAP will cover the initial 30-day supply with a Louisiana ID and a positive HIV test.
 - At the first visit they start the patients on a one month medication regimen which is a 30 day dose pack. They physically hold the patients' hands as they take their first pill.
 - 21-24 days after initiation, the patients are virally suppressed which is 98.7% of their patients.
 - The providers are now prioritizing the patients and this reinforces the You=You message.
 - They see approximately 500 patients under this model with the average age being 29.
 - For those enrolled after one year, 92% remained in care and 91% are virally suppressed.
 - They started the Rapid Start model in 2016 in one location. There are now six clinics in their organization and five of those perform Rapid Start.

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- Questions/Comments
 - Why don't we begin with 4-week starter packs of Biktarvy? This will give everyone 4 weeks to get all of the other pieces in place.
 - Would the state allow non-pharmacists have starter packs to give out?
 - Would this cause increased resistance?
 - The risk of that is very low. If you wait a month there is still a chance they will not adhere. Conditions for not giving a starter pack would be if they have TB or Meningitis.

For those who would like to learn more about the Rapid Start Program at Crescent Care in New Orleans, LA and Dr. Halperin's presentation and commentary, an email with the links will be sent out soon.

The meeting was adjourned. The agenda will resume at the next HIV Elimination Taskforce Meeting

Next Meeting Date and Time

HIV Elimination Taskforce January 30, 2020 - 2:00pm-3:30pm

Location: Freeway Medical Building Boardroom – Rm 906 - 5800 West 10th St., LR, AR 72204

Arkansas Department of Health
3rd HIV Elimination Taskforce Meeting Minutes
Thursday, October 24, 2019

Meeting Minutes

Welcome and Introduction

Welcome was extended by Dr. Nate Smith (Arkansas Secretary of Health) and Dr. Michelle Smith (Office of Minority Health & Health Disparities Director). Today's focus will be Pharmacies' role in eliminating HIV.

Presentations

- ❖ Kim Schalchin (Ryan White client) gave her personal story as someone living with HIV. Kim was diagnosed at the age of 35 in February 2015. She is a recovering drug addict and used to shoot up meth with out any concerns about contracting something. She went to the Lonoke Health Unit to renew her birth control. While there the nurse asked a series of questions and when she mentioned her drug use the nurse suggested she take an HIV test. At first, she thought it was a false positive. The LHU employee was not nice or compassionate. The counseling services she received through the LHU was cold and uncaring. It was a bad experience all together. The worst part was knowing her name is now in a database. Even after her diagnosis she still shot up since she now had a "death sentence" but that has all changed and she realized we all have a death sentence. She now sees Dr. Joseph Beck for her HIV care and he has made her life with HIV easier. She wished her experience had been better at the health department and with her previous case manager at ARcare . When she was diagnosed, her viral load was 12,000 and her CD4 was 570. Dr. Beck did not start her on meds right away because she was still shooting up. Once she did start the meds within two months her viral load was less than 20. She now tries to stay educated about HIV and being an advocate and help others. She is NOT HIV.

- Barriers she has faced
 - Meds upset her stomach so she missed a lot of work and she almost lost her job. She did not want to tell her employer why she was sick.
 - Ignorance about HIV
 - She did not face transportation or housing issues but she has friends who have
 - Health Department's staff that were not compassionate or caring.
 - ARcare case managers (in the past) who seemed more about a paycheck than being caring and supportive of their clients.
- Elimination and What It Means to Her
 - Freedom
 - Free to live without worrying about meds, from having to tell someone she is dating she lives with HIV, from stigma, from it affecting her family and friends, from not wanting to face the public.
- Questions/Comments
 - Kim was asked how she moved from a sense of hopelessness to wanting to get her life back. She could have stayed an active addict but she wants to make a difference and help others.

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3rd HIV Elimination Taskforce Meeting Minutes
Thursday, October 24, 2019

- ❖ Courtney Hampton (HIV Prevention & Viral Hepatitis C Program Manager) presented a recap of Pillar I: Diagnose - Barrier Gaps and Innovative Ideas to eliminate HIV.
- ❖ Dr. Michelle Smith presented a video that showed pharmacies offering rapid HIV tests
- ❖ Courtney Hampton spoke about Voluntary Counseling and Testing (VCT) Training which is available to anyone who would like to participate. It is a two day class that teaches you how to perform HIV tests and how to become a counselor held every three months. Contact Courtney at 501-661-2749 or Courtney.Hampton@arkansas.gov if you are interested in attending. Courtney also demonstrated how to perform a Antibody Rapid HIV test which produces results within 1 minute. It has a shelf life of 24 months. Oral Quick takes at least 3 months after exposure to provide accurate results. This test takes 21 days. Once someone tests positive they are referred to a local health unit or their primary doctor. A Disease Intervention Specialist (DIS) with ADH will be assigned to them to track down their partners to have them tested.
 - At the recent HIV/HEP C State Fair Testing Event – 682 people were tested two-weeks diagnosing 55 Hep C positives and 15 HIV positives.
 - The use of home HIV tests were discussed.
 - At a pharmacy, a home test costs about \$45.00.
 - Pro – Patients don't have to go to the LHU or their doctor to be tested
 - Pro – If we could make them free/low cost then that would remove stigma.
 - Con – Lack of reporting. Who is getting the results of the test? Reporting is not mandated by law in Arkansas
 - A suggestion was made to remove VCT training.
 - Arkansas is way behind the curve regarding home tests. It will be important to build relationships with community groups and to be creative. Self-testing has worked in other parts of the world, now by using an app where the patient takes a picture of the positive result and they send it in. There is no excuse for the tests to be \$45.00. The health department gets them for \$9.50. In India they are using self-test vending machines.
 - Kim (Schalchin) was asked if she would have taken a self-test and she said no because she did not think she had to worry about HIV. A barrier would be lack of educations. It depends on the situation if someone would take a test on their own.
 - Ideas regarding self-testing
 - Pair the tests with syringe exchange.
 - Link testing to benefits such as SNAP like vaccines were linked (very successfully) to WIC. Rebuttal to this - It would be bad public policy. Testing should not be tied to benefits to less fortunate. We would not ask the rich to be testing when submitting their tax returns.
 - Do a stigma analysis and provide education everywhere, not to those we deem as "high risk".
 - Provide incentives like they gave \$15 gift cards during the State Fair Testing Event.

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- Show an informational video at the DMV. With the new federal regulations regarding new driver's licenses will result in more traffic.
 - Largest barrier seen is that people don't think they need to be tested.
 - The group was reminded that there are ideas in place. We just need to implement them.
- ❖ Pharmacies' role in ending the HIV epidemic was discussed
- Largest Barrier - money. Pharmacies do not receive compensation for providing HIV tests and counseling. Some have reached out to pharmacies and they are not interested.
 - Small local pharmacies struggle to stay afloat. If they can be paid it would help. Also, the availability of HIV meds is a barrier for small pharmacies.
 - Walgreens was represented. They want to help communities but they also have to make sound business decisions.
 - Another barrier is the lack of consistent care across all locations. They have patient health rooms who allow community groups to use for testing but there is not enough staff utilizing these rooms.
 - Walgreens was praised for their help on HIV/AIDS Testing Day.
 - If pharmacies could establish an agreement with physicians and provide services including PreP, pharmacists would fill and monitor labs. This would be lucrative for pharmacies and bring in more business for the other things they sell.
 - Why can't the UAMS Pharmacy School train students to test and counsel for HIV like they do for diabetes and hypertension and then take that knowledge to local pharmacies. Start the training their freshman year.
 - Offer continuing education credits to pharmacists for their cooperation.
 - Geographically target a pharmacy (like in Chicot County) instead of targeting all of AR.
- ❖ Other things mentioned
- People in nursing homes are at risk for HIV
 - Anyone having unprotected sex, regardless if they are "high risk" or not are at risk.
 - A request was made to have Cornelius Mabin (Arkansas HIV Prevention Group Co-Chair) speak at a future meeting to discuss the great things his organization has been doing.

Next Meeting Date and Time

HIV Elimination Taskforce - November 21th, 2019- 2:00pm-3:30pm

Location: Freeway Medical Building Boardroom – Rm 906 - 5800 West 10th St., LR, AR 72204

Visit by Dr. David Reznick, Director, Oral Health Center's Infectious Disease Program, Grady Health
November 14, 2019

8:00am - Grand Rounds

Location: ADH Auditorium – Basement Level of ADH main building (4815 W. Markham, LR, AR 72205)

10:00am – Roundtable

Location: ADH Boardroom – 5th Floor of ADH main building (4815 W. Markham, LR, AR 72205)

Arkansas Department of Health
2nd HIV Elimination Taskforce Meeting Minutes
Thursday, September 19, 2019

Meeting Minutes

Welcome and Introduction

Welcome was extended by Dr. Nate Smith (Arkansas Secretary of Health) and Dr. Michelle Smith (Office of Minority Health & Health Disparities Director) as was the need for informed input on how to identify gaps in the four Pillars of HIV Elimination (Diagnose, Treat, Protect, Respond) and a reminder of the purpose of the HIV Elimination Taskforce in order to provide innovative ideas to create optimal conditions to eliminate HIV.

Presentations

- ❖ Latunja Sockwell (UAMS Family and Preventative Medicine Community Research Group Program Manager) gave her personal story as someone living with HIV and her current pursuits in HIV Elimination in her position at UAMS through active projects such as AR Passion Project, Gilead Drug Court Project and PrEP. LaTunja was diagnosed in 1997 while living in Prescott, AR. She identified the barriers she faced receiving HIV related care such as living in a rural community and the lack of treatment at her primary care doctor's office, doctors' lack of knowledge of HIV, the lack of someone to talk to (except her family) about her diagnosis and the far distance to her HIV provider's office in Texarkana from Prescott. At one point a doctor refused to perform an elective surgery on her because of her diagnosis and his fear "for his staff's safety".
 - Things Latunja would change
 - Who's "At Risk" – Who says anyone is at the "Highest Risk"?
 - Mass Testing
 - Primary Care – The fact PCPs will not treat HIV so a person must see an Infectious Disease Specialist for care. For those like herself who make too much income to qualify for the Ryan White Program, they must pay a Specialist Copay which is usually much more than that of a visit to a PCP.
 - Tracking Clients – Track those with HIV that are not on the Ryan White Program or are seen at ARCare.
 - Education in the Communities – Get HIV education into the schools
 - Medical Profession Education – Provide this especially in the rural areas
 - Elimination and What It Means to Her
 - Linkage to Care
 - New Positive Diagnosis down to none
 - Medical Trials – To see if shots could be used to treat HIV, not just pills
 - Budgets – Eliminate restrictions against good ideas because of the cost
 - Community Events – In a couple of weeks a PS2 gaming tournament has been set up in Prescott and all the participants will be tested

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2nd HIV Elimination Taskforce Meeting Minutes
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- Elimination and What It Means to Her (Continued)
 - New Grants
 - Project Heal – 2.5 million grant from SAMHSA to help African Americans in Pulaski County involved in the criminal justice system that uses the Healthy Love curriculum that shows people how to use condoms. Testing is included along with health screens and other wrap around services.
 - SOF (Save Our Futures) – Going into colleges and including internet based counseling
 - Need to Focus on HIV Decriminalization

Questions/Comments

- Dr. Naveen Patil (ADH) stated that they current not doing a trial but they are applying for a grant regarding injectable treatments and will work with Ms. Sockwell regarding this.

Sub-Committee Breakout Sessions

- ❖ Participants of the Task Force split into four groups to discuss the Pillars of HIV Elimination (Diagnose, Treat, Protect and Respond). The questions to be discussed in regards to each pillar were
 - What barrier gaps exist?
 - What innovative ideas do you have that could reduce those barriers?
- ❖ Those who chose Diagnose presented the answers to these two questions. All other pillars were discussed and will be presented at future Task Force meetings
 - Diagnose - Barrier Gaps
 - Reason to get diagnosed/tested
 - No insurance coverage
 - No access to care
 - Trust issues
 - Availability of testing and treatment
 - Reporting
 - Stigma
 - Lack of capacity
 - How we look at those who are “High Risk”
 - What are we doing for those who test negative? If they walk out with a negative result but nothing else, then that is a barrier
 - Lack of wrap around services
 - Doctors are not comfortable talking to their patients about their sexual health
 - We have created categories that have become stigma. We have separated health from sexual health
 - Risk identification and appropriate response
 - Language
 - Religion

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- Diagnose – Innovative Ideas
 - Look at those who are “High Risk” and change our way of thinking
 - Make the local health units “Sexual Health Units” or “Be Well Clinics”
 - Give more test kits to community groups
 - Give HIV tests when someone gets married or applies for a new ID
 - Focus on a person holistically
 - Test everywhere
 - Conduct media events and present PSAs
 - Concerts – Provide incentive for testing like \$10 off the ticket
 - Provide public awareness that it is not a death sentence
 - Air a series of commercials telling someone’s story (like the violence or cancer ones)
 - Learn from the Cancer Community
 - Create a campaign to keep it in people’s minds
 - Step out of the Central Arkansas Region
 - HIV patients can’t hide who they are
 - Get support groups in every county
 - Educate ALL providers with CDC risk factor information
 - Change conversations among physicians. Cancer is now normalized with screenings at age 40. Start the same with HIV testing at age 18
 - Include HIV testing as part of a wellness screening
 - Bring 3rd party payors (insurance companies) to answer what testing and treatment they will pay for
 - Electronic Medical Health Records should include HIV
 - Bring Legislators in to reduce or eliminate some barriers
 - Convince Arkansans to change their minds and hearts regarding HIV
 - Create and air HIV education podcasts

Next Meeting Date and Time

HIV Elimination Taskforce - October 24th, 2019- 2:00pm-3:30pm

Location: Freeway Medical Building Boardroom – Rm 906 - 5800 West 10th St., LR, AR 72204

Visit by Dr. David Reznick, Director, Oral Health Center’s Infectious Disease Program, Grady Health
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10:00am – Roundtable

Location: ADH Boardroom – 5th Floor of ADH main building (4815 W. Markham, LR, AR 72205)

Arkansas Department of Health
HIV Elimination Taskforce Meeting Minutes
Thursday, August 29, 2019

Meeting Minutes

Welcome and Introduction

Welcome was extended by Dr. Nate Smith (Arkansas Secretary of Health) and Dr. Michelle Smith (Office of Minority Health & Health Disparities Director) as was the purpose of the HIV Elimination Taskforce.

Presentations

- ❖ Jon Allen (ADH Infectious Disease Branch Physician Assistant) presented information to the Task Force regarding the background of Ending the HIV Epidemic and the four pillars outlined in the initiative (Diagnose, Treat, Prevent and Respond).

Questions

- Is distribution in Arkansas of individuals living with HIV evenly distributed or is it concentrated? What do we know that could help with this strategy?
 - **Answer:** While at UAMS, Jon saw patients from all over the state. Many travel from rural areas and that complicated care for them to get to their appointments. There are more cases in Central and NW Arkansas but patients are distributed all over the state. We need ways to bring care to them and ways they can get their labs and follow up care without traveling to an ID Specialist.
- Where do we have people living with HIV?
 - **Answer:** Most live in Central and NW Arkansas.
- Where do we have people living with HIV that lack access to services?
 - **Answer:** In the bare spots of the state where we do not have providers.
- ❖ Dr. Charles Bedell (ADH Infectious Disease Associate Branch Chief) and Tiffany Vance (ADH Infectious Disease Branch Chief) presented information and details regarding the Notice of Funding Opportunities (NOFO) released from CDC. The CDC NOFO has been submitted and funding is expected by September 30, 2019. This included the following deliverables:
 1. Medical Provider Engagement
 2. Consumer Engagement
 3. Update Epidemiological Profile
 4. Situation of Analysis
 5. Ending the HIV Epidemic Plan: Arkansas

Questions

- What is the funding announcement and what is it supposed to fund?
 - **Answer:** The Notice of Funding Announcement (NOFA) will be used to accomplish the five deliverables (above). They applied on July 12, 2019 and expect the award at the end of September.

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Presentations (Continued)

- What is the contingency plan if you are not awarded?
 - **Answer:** We are confident we will be awarded with this one. We have had communications with CDC earlier this week. Also because we are one of the 7 states chosen we are guaranteed funding (\$750,000) based on a good grant proposal.
- How comprehensive will the Situation Analysis be? Will it only look at HIV and treatment or will it look at the whole person and wrap around services?
 - **Answer:** We want to look at the whole person, the gaps we currently have in the state and any barriers. We want to present a full picture to CDC about our state and our need and where we are being able to reach consumers for medical care, treatment and retain them in care and the support services that will ensure we will be able to do those things.
- Has the tool/survey been created?
 - **Answer:** No, that is next.

Observations

- Dr. Nate Smith: We all know how HIV is transmitted. It is closely tied to social determinants (non-medical factors) of health, typically populations that have been neglected, have significant strengths that have not been utilized but also have significant challenges. It is more than a medical problem and there is an issue of health equity and that is why we are seeking this engagement to identify those challenges and address them as we are implementing some of these biometric tools to prevent the spread of HIV. This will help us identify gaps and to set priorities.

Questions

- What population of people will be included in the Situational Analysis? Are we including sex workers, those who are transgender? Are we including those people in our thought process?
 - **Answer:** We want to work with our community based organizations, federal qualified health centers. By partnering with the ADH Prevention community based organizations (since they have direct contact with those individuals) we will use their participation on the surveys and the focus groups. Yes, we want the involvement of everyone, especially those high risk populations.
- Historically when funds go through ADH you have organizations that may have the access but not the capacity needed. What will be different this time as far as policies are concerned to engage those organizations to do this work in a different manner?
 - **Answer:** As a part of this effort we can talk even more about that. We will have an Agency Consumer Meeting Group that will discuss these efforts to see how we can work with the agencies to complete everything we have to.

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Observations

- Dr. Charles Bedell: We may not have all of the answers at the moment but that is the purpose of the task force and to come up with an informed plan to end the epidemic in the state.
- Dr. Nate Smith: Some community groups may have access to those at risk and knows how to work with those with HIV but not have the administrative capacity to manage a grant and jump through the hoops like a state agency can. That is a real problem and it is more of a problem in the rural areas. This is part of what has to be addressed to end the epidemic. Innovative approaches is part of what we are looking at.
- Unknown: It is not the ability to manage the grant, it is the application piece to the grant.

Presentations (Continued)

- ❖ Dr. Charles Bedell and Tiffany Vance also presented information and details regarding a second Notice of Funding Opportunities (NOFO) released from the Health Resources and Services Administration (HRSA). The HRSA NOFO is due October 15, 2019. The purpose is HIV prevention. This included the following deliverables:
 1. Increase and Expand Testing
 2. Achieve 90% Viral Load Suppression for HIV Positive Persons
 3. Ensure HIV Negative Persons Remain Negative
 4. Sustain Cooperation and Collaboration for ETHE through Early Identification of Individuals for HIV/AIDS beyond 2030.

Discussion (Question presented by Dr. Michelle Smith)

Knowing what you know, what are some of the barriers that you think we will face in implementing this and what is your willingness and capacity within your agency to help us get there?

- **Answer:** Deidra Levi (Director of HOPWA) - Barriers: Talking to stakeholders is not the problem. It is reaching those outside of the HIV community that needs to buy in such as the Razorbacks, pastors and clergy across the state. Someone else talking about this besides us. Urban sanctuary – gap in healthcare in the Black LGBT community. We have always been willing to do what is needed but we lack the capacity to have the funds to do what is needed.
- **Answer:** Cornelius Mabin (HIV Prevention Co-Chair) stated that the HPG organizations has been working for years to invite stakeholders (legislators, clergy, etc.) and they have had empty chairs. There has been a mechanism in place that has reached out to the community for decades. HPG meets bi-monthly and everyone in this group is invited to attend.
- **Answer:** Arkansas Dept. of Correction Representative: Barriers In regards to inmates: One of the gaps for this population is they are going from state agency to state agency but they almost all run out of the drugs and lose contact for a follow-up. Those that come back (into ADC custody) who have been off treatment are harder to treat.

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Continuity is needed. There is lots of time to plan for discharge but the left hand is not working with the right.

- **Question:** Are these individuals available for Arkansas Works when they are released? Flexibility in the Medicaid enrollment is needed to get them on the program when they are released.
 - **Answer:** Correct.
 - **Answer:** We could transiently enroll them in the Ryan White Program to cover their medications until other forms of payment come through
- **Question:** Accomplishing our goals is related to socioeconomic determinants. Even if we get all of the insurance issues lined up we are still losing people from the time they leave prison until their first appointment up to 4 weeks later. Is there an organizational process on the outside to receive these people and support them socially?
 - **Answer:** That is a million dollar question. There are close to 18,000 prisoners and over 5,000 in the county jails and none of those are tested (for HIV/AIDS). When we incarcerate these people we don't have the resources. We have all these data points and there is no integration (between state agencies).

Observations

- Dr. Gary Wheeler: In Cuba (5 or 6 years ago), HIV was treated in sanitariums by locking up HIV patients there to keep them away from the general population. As therapy became available they treated all of these people, dealt with any with drug addiction. When they were discharged they went to a team in their community who was responsible to keep them on track. He was not aware of anything like that here. In the 80s there were teams of people who helped with those with HIV.
- **Question:** How can we fill that gap to connect, not just those in prison, but all people when they receive their diagnosis to fulfill their goals? The Ryan White Program is there but there are some community elements that are missing.
 - **Answer:** We already have community health workers. The challenge in our state is we do not get reimbursed for those services. Medical providers take a risk hiring people and not being reimbursed for the services. We know what works. The real issue is can we overcome a lack of will we seem to have to do it. We have to convince policy makers to hone in on this issue. We know how to solve it and let's get it done.
- Unknown: Another barrier is traditional thinking in terms of how to deliver services. The medical service model is 9-5. Our expectation is patients will come to see the service provider instead of the provider going to the patients. The expectation is that a provider must have some credentialing beyond a Bachelor's degree. If we can break out of the traditional mold of how we deliver services and define health. This is a disease that is so stigmatized that if we put a kiosk in Walmart who would be willing to walk up if it said HIV testing on the side. Dealing with the stigma is a big part of ending the epidemic. If we don't deal with it we will be here in 10 years.

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- **Question:** Do we know the number of inmates in ADC custody with HIV?
 - **Answer:** Yes
- Rep. Fred Love: (Going back to those in ADC custody) We have a source of funding through HOPWA. If we don't stabilize a person's housing they will not stay in care. We could start a pilot project with HOPWA (Housing Opportunities for People With AIDS) funds to target this population and provide support. We could test if keeping them in housing would stabilize and keep them in care. This is not policy, it is if we are going to do it or not. We have the resources. We can target the inmate population with this.
- Dr. Nate Smith: Housing AND Transportation are barriers (to care).
- Tiffany Vance: Our Ryan White Program has worked with ADC. She likes the idea of working with HOPWA and connect that with the Corrections to care effort.
- Rep with ADC: Steps were given of what happens when an inmate is released and is HIV positive. (ADH (Gisele Hudson) is contacted, Dr. Moore (ARCare) is contacted along with other providers on the outside). Those on parole must have a parole plan in place which includes housing. If it does not then they will not be released. The inmate fills out a form that is released to these entities.
- Unknown: This could also apply to LGBT youth with the same concerns. People who are incarcerated are an easy target.
- Dr. Nate Smith: The population that drives the Epidemiology numbers are those that are recently infected.
- Unknown: Let's change the message. Let's make Arkansas the first to do something different.

Discussion (Question presented by Dr. Michelle Smith)

What is your agency's ability for system expansion (telemedicine usage, monitoring, etc.) and legal parameters for exchanging data and information between agencies?

- **Answer:** The exchange of information does not seem to be a problem

Observations

- More stakeholders are needed in this discussion (like legislators) that are not in this room and not directly impacted
 - **Answer:** We will do that
- You most likely would not be able to share the information (provided by ADC to providers) to faith based and community groups to help people stay in care.
 - **Answer:** That is why we work with ADH (Gisele Hudson) and the Ryan White Program to get them the help they need and I know that is what they do to provide help. Once they leave ADC custody, the ADC rep has nothing else to do with them.
- Dr. Smith: All of this would be great to discuss as sub-groups. (A sign up list for these subgroups was passed around later in the meeting).
- Unknown: How can we increase capacity for testing? Home testing and self-testing but people with probably not want to pay \$45 for the test. This is a critical area we are not doing an adequate job.

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- Dr. Dan Moore (ARCare). ERs should be doing HIV testing but they aren't. He is meeting next week with rural ER staff to see how we can increase HIV testing.
 - **Question:** Why are the ERs not testing for HIV?
 - **Answer:** They don't want to follow up
 - **Question:** Would it help if a community health center agreed to provide follow-up to ERs?
 - **Answer:** Yes, that would definitely help
 - **Answer:** We can use Ryan White to link that care and then get them a local doctor to provide care and recruit providers to provide HIV care.
- Dr. Nate Smith: A project we tried was putting Telemedicine in the Local Health Units but it didn't work. That is not where people want to receive their HIV care. We need to find out how they want to receive their care.
- UAMS Technology Rep: Telemedicine can reach people using smartphones/apps using a platform that is web based and is encrypted. There is also technology (connected to their pill bottle) that will let the system know if they are compliant of taking their medicine. A Health Navigator is being used through UAMS for cancer and other diseases.
- Dean Mark Williams: A subgroup is needed consisting of pastors and bishops to activate congregations and address stigma.
- Dr. Bedell: We are missing the Oral Health care providers (at the table).
- Unknown: We need people impacted at the table (sex workers, LGBT homeless, transgender, 18-25 year old black males who have sex with males.)
- Dr. Alisha Cragbill (Healthcare Pharmacy): The UAMS College of Pharmacy trains students (in their first year) to do testing blood sugar, cholesterol, etc.). We could include HIV testing. Dr. Jeremy Thompson is the contact for this.
- Cornelius Mabin: All of this has been talked about for years. What are we going to do about it?
- Dr. Nate Smith: Amen. We need to have these same conversations with different people.
- Dr. Michelle Smith: Please email her names of those you may want to add to the table.

Next Meeting Date and Time

September 19th - 2pm-3pm – HIV Elimination Taskforce